

Su 3

WILL THEY BE WITH US TOMORROW?:

Chaplains in Suicide Prevention

REPRINTED
FOR
UNIT
LEADERS

Prepared by the
Chaplain Resource Board
and Reproduced by the Family Programs Branch,
Headquarters Marine Corps

D 214.2:

READER
EIGHT

best copy available



DEPARTMENT OF THE NAVY
HEADQUARTERS UNITED STATES MARINE CORPS
WASHINGTON, D.C. 20380-0001

IN REPLY REFER TO
1752/4
MHF:FP11
11 SEP 1986

Dear Unit Leader,

The booklet, Will They Be With Us Tomorrow?, was originally prepared by the Chaplain Resource Board and has been reprinted by the Family Programs Branch for you. The booklet contains excellent information on suicide - including identification of those at risk and what steps you can take to prevent suicides in your command.

The Commandant's White Letter 3-86 on Suicide Prevention reminds leaders of their responsibilities in helping eliminate the tragedy of Marines taking their own lives. The White Letter reviews Marine Corps suicide statistics which reveal that:

- About 30 Marines commit suicide each year.
- Nearly 80 percent of those who attempt or commit suicide give warning of their intention.
- More than 40 percent of suicides occur within the first 6 months at a new duty station.
- About 75 percent of the Marine suicides are committed with a firearm, usually a personally owned handgun.

Marines experiencing personal crises need to know that someone cares and will respond. This attitude of caring must begin with unit leaders and filter down to Marines at all levels of leadership so they are alert to the possibility of suicide attempts among their fellow Marines.

We hope that this booklet will be a first step in increasing your awareness and knowledge on the subject of suicide.

E. C. CHEATHAM, JR.
Lieutenant General
U.S. Marine Corps
Deputy Chief of Staff
for Manpower

DISTRIBUTION: A
DIR, FSC (5)

ACKNOWLEDGMENTS

We wish to express our sincere gratitude to the many individuals and organizations who directly or indirectly contributed to this report. We are particularly indebted to the following for their specific assistance as described below.

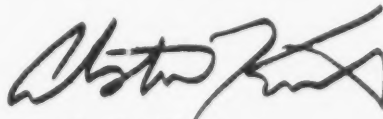
To the American Association of Suicidology for their assistance in providing statistical data regarding rates of suicide nationally. To the staff of Merck Sharp & Dohme's Health Information Services for their fine array of brochures and information sheets.

We especially want to thank Dr. Alan Berman of the Washington Psychological Center for his excellent support and for providing us with material not yet published in the area of adolescent suicide. We are also indebted to the staff of the Military Family Resource Center, Washington, DC for many contributions and suggestions for additional research.

We would like to express my deep appreciation and indebtedness to the Commanding Officer of the Naval Health Research Center, San Diego, CA and especially to LT R. B. Chaffee, MSC, USNR for his exceptionally fine reports on suicide within the Navy and Marine Corps.

The U. S. Army Chaplain Board was most helpful in providing material produced for conducting suicide prevention programs at the unit level. The article "Caring: A Positive Approach to Suicide Prevention" was particularly insightful.

Finally, we would like to thank Commander Jerry Turner, CHC, USN, for providing his manuscript on suicide done as part of his Doctor of Ministry program. This material was used in presenting the historical background on society's response to suicide.



A. S. KIRK
Captain, CHC, USN
Director
Chaplain Resource Board

CONTENTS

	Page
ACKNOWLEDGMENTS.....	i
CONTENTS.....	ii
SECTION I - INTRODUCTION.....	1
SECTION II - ISSUES IN SUICIDE PREVENTION.....	2
Why Suicide?.....	2
What Causes Suicide?.....	2
What Are the Facts?.....	3
Depression.....	5
Some Signs of Suicide.....	6
Immediate Danger Signals.....	7
What to Do.....	7
What Not to Do.....	9
Remember.....	9
SECTION III - THE DEMOGRAPHY OF SUICIDE WITHIN THE NAVY AND THE MARINE CORPS.....	10
Summary.....	13
APPENDICES	
A - SUICIDAL BEHAVIOR.....	14
B - CLASSIFYING SUICIDAL BEHAVIOR.....	16
C - EVALUATING A SUICIDE.....	18
D - ASSESSMENT OF A SUICIDAL RISK.....	20
E - SUICIDAL ASSESSMENT.....	21
F - SIX STEPS ON THE MANAGEMENT OF A SUICIDAL PERSON.....	23
REFERENCES.....	24

SECTION I

INTRODUCTION

Suicide among young adults is a serious and growing problem. There has been a 300 percent increase in the adolescent suicide rate since 1962. More than 6,500 young Americans kill themselves each year. Taking all age groups into account, nearly 30,000 Americans die by their own hand each year. There are over 1,000 suicide attempts in the United States daily or one every minute of every day. Nationally, suicide is the tenth leading cause of death. In persons 14 to 25 years of age, it is the third leading cause of death. These figures may in fact be higher as most researchers feel that many suicides are not reported as such. (12:56; 49:4-5; 26:63)

The term suicide, with its Latin structure, was actually unknown in antiquity. The ancient Latins used expressions such as: *sibi mortem consciscere* - to procure one's own death; *sua manu cadere* - to fall by one's own hand; and *vim sibi inferre* - to do violence to one's self. In England the early term was self-homicide, reflecting the prohibition "Thou shall not kill." Our current word "suicide" seems to be a 17th century neoformation. (56:7)

History has not treated the suicide victim or his/her family very kindly.

In Athens, a hand was lopped off the cadaver in hopes that the vengeance of the returning ghost [would not take place.] In Metz, those who committed suicide were put in barrels and floated down the River Moselle. In much of Western Europe in the Middle Ages, the body of a suicide was buried at night, at a crossroad with a stake transfixing through his heart...In ancient Rome at one time, suicide was prohibited in the case of criminals, slaves and soldiers. Criminals awaiting a trial might be tempted to kill themselves to avoid a sentence or the confiscation of their property at the time of the trial. To plug the loophole, the law required the confiscation of the property of suicides...Not many suicides are recorded in European society between 400 and 1400 A.D. In that society, a suicide was uniformly condemned by the church [Roman Catholic] as a sin and by the State as a crime. (56:11-12) [Emphasis added]

Chaplains, by virtue of their training and experience, can become potent and powerful allies of life to the person contemplating suicide. This paper will point out some of salient features of suicidal ideation; methods for preventing suicide; and finally provide some demographic data regarding suicide within the United States Navy and the United States Marine Corps.

SECTION II

ISSUES IN SUICIDE PREVENTION

WHY SUICIDE?

There is no simple answer as to why people choose to kill themselves. Usually, the emotional upset is so great that the person "just wants to stop the pain." They feel helpless, hopeless, and worthless. Often they believe that it does not matter if they live or die and that no one would miss them. Suicidal people feel that they cannot cope with their problems and that suicide is the only possible way to escape unbearable pain.

Ray and Norbert describe adolescence as a "roller-coaster". They go on to say:

This period of growth, mentally, physically, emotionally and socially is characterized by rapid change. It is the most intense phase of development, bringing more changes than at any other time in life. Actually, it is a time when too many changes are taking place too fast for some youths to cope.... One of the biggest changes for adolescents...is shedding the relatively comfortable role of a child for that of a responsible adult. (33:131)

Jean Baechler's seminal work, Suicides offers a description of suicidal behavior as found within eleven different types. This material is provided in Appendix A.

WHAT CAUSES SUICIDE?

In trying to understand why people kill themselves, it is tempting to look at the source of stress in their lives. An analysis of life stressors is not, however, the answer. Stress is a normal part of life and people are usually able to cope. Actually, most people think about suicide at sometime during their lives. Usually they find that these thoughts are temporary and that things do get better. Generally, it is a combination of events that lead a person to believe that suicide is the only way out. One common thread is that the person feels hopeless about life. Feelings of hopelessness and low self-esteem have many causes:

° Break up of a close relationship with a loved one or difficulties in interpersonal relationships with family or close friends.

° Death of a loved one; spouse, child, parent, sibling, friend, or pet.

° Worry about job or school performance and concerns about failure or doing less well than one hoped or expected.

° Loss of "support system" or "emotional safety" which comes from moving to a new environment.

° Loss of social or financial status of the family.

° The compounding and disorienting effects of drugs and/or alcohol.

WHAT ARE THE FACTS?

An encounter with a suicidal person is always a deeply emotional experience. There is a fear of not knowing what to do, or doing the wrong thing. However, just telling someone "I care about you" indicates that there is hope and help. Misinformation often prevents potential helpers from becoming involved for fear of making the situation worse. There are many myths about suicide which keep us from becoming involved. What are some of these myths and what are the facts?

1.

FABLE: People who talk about suicide don't commit suicide.

FACT: Of any ten persons who kill themselves, eight have given definite warnings of their suicidal intentions. Do not ignore suicide threats. Statements like "You'll be sorry when I'm dead," "I can't see any way out,"--no matter how jokingly or casually said--may indicate serious suicidal feelings. (47:2)

2.

FABLE: Suicide happens without warning.

FACT: Studies reveal that the suicidal person gives many clues and warnings regarding his suicidal intentions.

3.

FABLE: Suicidal people are fully intent on dying.

FACT: Most people are undecided about living or dying, and they "gamble with death," leaving it to others to save them. Almost no one commits suicide without letting others know how he is feeling. "Most suicidal people do not want death; they want the pain to stop." (47:2)

4.

FABLE: Once a person is suicidal, he is suicidal forever.

FACT: Individuals who wish to kill themselves are suicidal only for a limited period of time.

5.

FABLE: Improvement following a suicidal crisis means that the suicidal risk is over.

FACT: Most suicides occur within about three months following the beginning of "improvement," when the individual has the energy to put his morbid thoughts and feelings into effect.

6.

FABLE: Suicide strikes much more often among the rich--or, conversely, it occurs almost exclusively among the poor.

FACT: Suicide is neither the rich man's disease nor the poor man's curse. Suicide is very "democratic" and is represented proportionately among all levels of society.

7.

FABLE: Suicide is inherited or "runs in the family."

FACT: Suicide does not run in families. It is an individual pattern. Chaplains should be aware, however, that individuals who have experienced a suicide within their family or in the life of a close friend may be susceptible to making a suicide attempt. Your response should focus on the individual's actions rather than upon hereditary factors.

8.

FABLE: All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.

FACT: Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, he is not necessarily mentally ill. (11:130)

9.

FABLE: Suicide is an act of impulse with no previous planning.

FACT: Most suicides are carefully planned and thought about for weeks.

10.

FABLE: A person who attempts suicide will not try again.

FACT: Most people who commit suicide have made previous attempts.

11.

FABLE: Because it includes the holiday season, December has a high suicide rate.

FACT: Nationally, December has the lowest suicide rate of any month. During the holiday season, the depressed person feels a sense of belonging and feels things may get better. As spring comes and their depression does not lift, the comparison of the newness and rebirth of spring and their own situation can produce overt self-destructive behavior. (49:2-3)

12.

FABLE: Talking about suicide may give someone the idea.

FACT: You don't give a suicidal person morbid ideas talking about suicide. The opposite is true. Bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do.

13.

FABLE: People who commit suicide are people who were unwilling to seek help.

FACT: Studies of suicide victims have shown that more than half had sought medical help within six months before their deaths. (47:2)

DEPRESSION

Depression is often associated with suicide. In 75 to 80 percent of all suicides, depression is a contributing factor. Sadness and an occasional "case of the blues" are normal emotions common to everyone. However, depression, an abnormal emotional state, is a profound sadness which is present nearly everyday for at least two weeks. Steven P. Roose, et al. has observed "that people who commit suicide have a high incidence of depressive syndromes...." (35:1159) Depression is characterized by:

- ° Poor appetite or significant weight loss or increased appetite or significant weight gain.
- ° Change in sleep habits, either excessive sleep or inability to sleep.
- ° Behavioral agitation or a slowing of movement.
- ° Loss of interest or pleasure in usual activities or decrease in sexual drive.
- ° Loss of energy, fatigue.
- ° Complaints or evidence of diminished ability to think or concentrate.

- Feelings of worthlessness, self-reproach, or excessive guilt.
- Withdrawal from family and friends.
- Drastic mood swings.
- Sudden change in behavior. (49:3-4)
- Worry about money, illness (real or imaginary).
- Fear of losing control, going crazy, harming self or others.
- Feeling helpless, "nobody cares," "everyone would be better off without me."
- No hope for the future, "it will never get better, I will always feel this way."
- Drug or alcohol abuse.
- Loss of religious faith.
- Nightmares.
- Agitation, hyperactivity, restlessness. (47:1; cf. 33:132)

SOME SIGNS OF SUICIDE

Historical factors have been identified which, when present, should cause us to increase our vigilance. Any person is at greater risk of suicide if they have:

- made a previous suicide attempt.
- a family history of suicide.
- lost a friend through suicide.
- been involved with drugs or alcohol.
- alcoholics in the family.

Appendix B provides a useful list for assessing suicidal risk. Prepared by Charles Neuringer, it lists eleven different classes of suicidal persons.

IMMEDIATE DANGER SIGNALS

When one or more of the following are observed in a person (especially someone who is or has experienced some of the life stress events associated with suicide, who appears to be depressed, and has a history known to cause increased risk of suicide) suicidal behavior may be imminent:

- ° Talking about or hinting at suicide.
- ° Giving away possessions; making a will.
- ° Obsession with death; sad music or sad poetry. Themes of death in letters or art work.
- ° Making specific plans to commit suicide.
- ° Buying a gun or having access to some other lethal means.

The Los Angeles Suicide Prevention Center has prepared a list of symptoms for the potential suicide. This list is found in Appendix C. You should note that the list is in no special order and the items are not weighted in value. The chaplain should stress the number (the more symptoms, the greater risk) and the degree in which these symptoms are manifested. Appendix D, also prepared by the Los Angeles Suicide Center, assists the determination of suicidal ideation on the basis of "intensity" of a behavior or symptom. Douglas Freeman's typology (Appendix E) assesses risk based upon an individual's intentionality (the degree of seriousness or purpose with which an individual is approaching the act).

WHAT TO DO

If you believe that someone may be suicidal, it is important to remember:

° Take threats seriously. Trust your suspicions. It is easy to predict suicidal behavior when a person shows most of the factors given above. However, the warning signs from many people are very subtle. Something like telling loved ones "goodbye" instead of "good night" may be the only clue. It's amazing the number of people who do not take threats seriously! Domino, et al., in their article entitled: "Attitudes Towards Suicide: A Factor Analytic Approach" indicate that most people (56%) do not take threats seriously. (25:261)

° Answer cries for help. Once you are alerted to the clues that may constitute a "cry for help" from a loved one, friend, or co-worker, you can help in several ways. The most important thing is not to ignore the issue. It is better to offer help early than to regret not doing so later. The first step is to offer support, understanding, and compassion, no matter what the problems may be. The suicidal person is truly hurting.

° Confront the problem. If you suspect that a person is suicidal, begin by asking questions.

[You] may begin with a statement such as, "You sure don't seem to have been yourself lately." "You appear to be kind of down." "Is something bothering you?" An affirmative answer to any of these might lead to another question, such as, "Are you feeling kind of depressed?" An affirmative answer to that question might result in a question such as, "I guess sometimes it seems as though it's not worth it to go on struggling and fighting when so many disappointing things happen to you." An affirmative answer to that question might lead to, "Do you sometimes wake up in the morning and wish you didn't have to wake up, wish you were dead?" A "yes" might lead to, "Have you been thinking about killing yourself? Has suicide been on your mind?" (42:n.p.)

Be direct. Don't be afraid to discuss suicide with the person. Getting him to talk about it is a positive step. Be a good listener, and a good friend. Don't make moral judgments, act shocked, or make light of the situation. Offering advice such as, "Be grateful for what you have," or "you're so much better off than most," may only deepen the sense of guilt the person probably already feels. Discussing it may help lead the person away from actually doing it by giving him the feeling that someone cares.

It is interesting to note that several researchers have repeatedly emphasized the importance of attitude within the helper [chaplain]. David J. Inman, et al, has suggested that one's belief about suicide prevention is more important than having interventionist skills or knowledge about suicide mortality. (29:183-4)

° Tell them you care. Persons who attempt suicide most often feel alone, worthless, and unloved. You can help by letting them know that they are not alone, that you are always there for them to talk to. Tell loved ones how much you care about them, and offer your support and compassion. By assuring the person that some help is available, you are literally throwing him a life-line. Remember, although a person may think he wants to die, he has an innate will to live, and is more than likely hoping to be rescued.

° Get professional help. The most useful thing you can do is to encourage the person who is considering suicide to get professional help. If necessary, offer to go with them or take them to help. The Navy community offers many sources of help. Navy Regional Medical Centers and Clinics should be considered first in looking for help. After normal working hours, the emergency room would be the best source. Appendix F cites a six step management program for the suicidal person. Chaplains will in all likelihood be involved with an individual for the first five steps. Therapy (step 6) will usually take place outside of the command. Nevertheless, the chaplain can provide a continuity with the individual and at the same time offer continued pastoral care. Nor does pastoral care end with the individual's return to the unit. Oftentimes these individuals will be considered "at risk" some four to six months after their return to duty.

When the danger is less immediate, the Family Services Center or yourself may offer compassionate counseling resources.

[Another] very effective method of preventive counseling is known as the ABC Method. In step A, the counselor **acquires** information and establishes a rapport with the [individual]. Step B consists of boiling down the situation. It is this stage that reveals if the client has a true crisis by uncovering the stress involved. By the end of step B, the counselor knows how the client feels about the problem and the underlying causes. Step C is the coping stage, in which the counselor helps the client decide how best to handle the situation. The ABC Method is workable because it gives the counselor the confidence that he or she needs to stay in control and to be the source of strength the client needs. (33:134)

WHAT NOT TO DO

- ° Don't leave anyone alone if you believe the risk of suicide is imminent.
- ° Don't assume the person isn't the suicidal type.
- ° Don't act shocked at what the person tells you.
- ° Don't debate the morality of self-destruction or talk about how it may hurt others. This may induce more guilt.
- ° Don't keep a deadly secret. Tell someone what you suspect.

REMEMBER

Suicide is a traumatic event for the individual and for all those people who have some connection with the person. Edwin Schneidman, Ph.D., founding president of the American Association of Suicidology, has stated: "Human understanding is the most effective weapon against suicide. The greatest need is to deepen the awareness and sensitivity of people to their fellow men." (49: 5)

SECTION III

THE DEMOGRAPHY OF SUICIDE WITHIN THE NAVY AND MARINE CORPS

The following information was provided by the Naval Health Research Center located in San Diego, CA. (60)

Navy and Marine Corps Completed Suicides by Year and Branch of Service: 1974-1984								
Year	Active Duty Navy				Active Duty Marine Corps			
	All Ranks		Enlisted Only		All ranks		Enlisted Only	
	<u>N</u>	<u>Rate</u>	<u>N</u>	<u>Rate</u>	<u>N</u>	<u>Rate</u>	<u>N</u>	<u>Rate</u>
1974	47	8.50	40	8.32	28(c)	14.70	(e)	
1975	35	6.52	29	6.21	26(c)	13.41	(e)	
1976	40	7.59	31	6.76	24(c)	12.54	(e)	
1977	52	9.86	48	10.44	25(c)	13.19	(e)	
1978	(a)		35	7.60	N/A			
1979	(a)		15	3.27	N/A			
1980	43	8.16	41	8.94	26	(d)	24	(d)
1981	69	12.82	64	13.68	35	(d)	33	(d)
1982	46	8.31	44	9.15	26	(d)	26	(d)
1983	69(b)	12.82	66	13.43	9	(d)	9	(d)
1984	53(b)	9.22	53	10.61	N/A			

Rates are per 100,000 persons

Notes:

- (a) No figures on completed suicides available for officers.
- (b) In addition to these cases, there are 31 cases in 1983 and 50 cases in 1984 which are pending further investigation before a determination of completed suicide can be made. If these additional cases are included, the suicide rates for officers and enlisted Navy personnel for these years would be 17.67 and 17.92 respectively.

- (c) These include males only. No information is available on female completed suicide for these years.
- (d) No strength figures were available at the time, preventing calculation of rates.
- (e) The numbers of completed suicide for these years were not broken down by pay grade.

Completed Suicides by Branch of Service				
	USN		USMC	
	N=97	%	N=25	%
<u>Rates/Ranks</u>				
Recruit	11	11.3	4	16.0
Apprentice	6	6.2	6	24.0
Unrated	24	24.7	3	12.0
3rd	15	15.5	5	20.0
2nd	16	16.5	3	12.0
1st	10	10.3	1	4.0
Chief	5	5.1	1	4.0
Ensign	3	3.1	0	0
LtJG	1	1.0	1	4.0
Lt	3	3.1	0	0
LCDR	1	1.0	1	4.0
CDR	2	2.1	0	0
<u>Method</u>				
Own Firearm	40	41.2	12	48.0
GI Firearm	4	4.1	7	28.0
Hanging	22	22.7	2	8.0
Overdose	6	6.2	1	4.0
Poison Air	11	11.3	2	8.0
Jumping	7	7.2	1	4.0
Drowning	1	1.0	0	0
Other	6	6.2	0	0

Among Navy personnel, alcohol was involved in 41 cases or 42.3% of all cases.

Among USMC personnel, alcohol was involved in 5 cases or 20% of all cases.

Among Navy personnel, most suicides occur at home (37), followed by off base (15) and duty-ship (14).

Among USMC personnel, most suicides occur at home (10), followed by on base (5) and duty other(5).

Among Navy suicides, 38 or 39.2% had a history of previous psychiatric disturbance.

Among USMC suicides, 8 or 32.0% had a history of previous psychiatric disturbance.

Among Navy suicides, 27 (27.8%) left a suicide note and 22 (22.7%) had made a verbal threat to kill themselves before actually doing so.

Among USMC suicides, 8 (32%) left a suicide note and 6 (24%) had made a verbal threat to kill themselves before actually doing so.

Completed Suicides by Branch of Service (Continued)				
	USN		USMC	
	N=97	%	N=25	%
<u>Sex</u>				
Male	92	94.8	23	92.0
Female	5	5.2	2	8.0
<u>Race</u>				
Caucasian	92	94.8	21	84.0
Black	3	3.1	4	16.0
Unkown	2	2.1		
<u>Age</u>				
Mean Age	25.4		24.5	
Mean LOS (in months)	60.0		58.6	
<u>Reason for Suicide</u>				
Difficulty with				
Love Object	44	45.4	9	36.0
Difficulty with				
Job/Service	32	33.0	9	36.0
Trouble with Law	18	18.6	2	8.0
Financial	12	12.4	4	16.0
Suffering Psychosis	3	3.1	0	0
Medical Problems	9	9.3	2	8.0
Death of Loved One	3	3.1	1	4.0
Alleged Sexual				
Deviation	5	5.1	0	0
Recent or Pending				
Separation	30	30.9	3	12.0
Quarreled or Fought	18	18.6	3	12.0
Infidelity an Issue	9	9.3	0	0
Wants out of Service*	6	6.2	0	0
Disciplinary*	7	7.2	6	24.0
Interpersonal*	22	22.7	4	16.0

*Note: These were coded only for the 1983 data.

SUMMARY

The following is quoted from a report prepared by LT R. B. Chaffee, MSC, USNR, entitled "Completed Suicide in the Navy and Marine Corps":

The rates of completed suicide for the Navy and Marine Corps by year of occurrence and pay grade found in this study are below the rates for the general U.S. population for white males and for white males 15- to 24-years olds. Marine Corps junior enlisted personnel is the only subgroup with a rate that approaches the rate for the general population. However, comparisons between the rates for military males and those for the general white male population must be made with caution because of differences in racial characteristics, age distributions, and time periods as well as in methods of observing and reporting on military and civilian populations. The military samples reported here included males of all races and there are proportionately fewer white males in the Navy and Marine Corps than in the civilian population. Younger age groups are overrepresented in the military and there are relatively few men over 45 years of age on active duty. These demographic factors are relevant because white males and men over 45 have higher rates for completed suicide than males of other racial groups and younger men.... Time periods differ for the military and civilian rates presented here because the military samples span 12 years [1966-1977]. During that time, rates for completed suicide among the general population have increased. In contrast, no perceptible trend is apparent in the annual rates for the military samples presented here. Finally, the military population is a selected subsample of the general population given the selection criteria and performance standards military personnel must meet in order to enter and remain on active duty.

The clear-cut differences between Navy and Marine Corps completed suicides found in this study indicate that it is necessary to specify the branch of service when studying suicide in the military population. Further, age, pay grade, length of service, and method of injury all appear to be salient variables in describing service members who completed suicide. When compared with the Navy, the Marine Corps, with the exception of senior enlisted personnel, shows much higher incidence rates for completed suicide. In addition, the marines as a group were younger, more likely to be in their first four years of service, and more likely to utilize small arms than the Navy's sample. Conversely, Navy completed suicides were more evenly distributed across age, pay grade, length of service, and method of injury categories. (59:6-7)

APPENDIX A

SUICIDAL BEHAVIOR

Jean Baechler in his insightful work entitled *Suicides* has detailed suicidal behavior into four general categories containing eleven different types: (02:63)

I. ESCAPIST

1. *Flight*: an escape from a situation sensed by the subject to be intolerable.
2. *Grief*: occurs following the loss of a central element of the subject's personality or way of life.
3. *Punishment*: occurs in order to expiate a real or imaginary fault.

II. AGGRESSIVE

1. *Vengeance*: is intended either to provoke another's remorse or to inflict the opprobrium of the community on him.
2. *Crime*: involves another in one's own death.
3. *Blackmail*: puts pressure on another by depriving him of something he holds dear.
4. *Appeal*: informs one's friends and neighbors that the subject is in danger (the suicidal act is a sort of alarm signal).

III. OBLATIVE

1. *Sacrifice*: seeks to save or to gain a value judged to be greater than personal life.
2. *Transfiguration*: seeks to attain a state considered by the subject to be infinitely more delightful.

IV. LUDIC

1. *Ordeal*: entails risking one's life in order to prove oneself or to solicit the judgment of others.

"A young man can wish to prove to himself that he is capable of facing danger and privation; he may be constrained to do so by community customs; most probably, the two objections are simultaneously sought: by proving his value to others, he proves it to himself and vice versa." (02:182)

2. *Game*: is to take a chance on killing oneself where the sole purpose is to play with one's own life. (02:63)

'Chicken' is played by two drivers on a road with a white line down the middle. Both cars straddle the white line and drive toward each other at top speed. The first driver to lose his nerve and swerve into his own lane is 'chicken'--an object of contempt and scorn--and he loses the game. The game is played among teenagers for prestige, for girls, for leadership of a gang, and for safety (that is to prevent other challenges and confrontations.) (02:175)

By combining the elements involved in the three questions (how? what? and for whom?), it is not difficult to isolate a certain number of real behavioral ordeals. Thus:

1. A young man confronts the hostility of the environment to prove his value to himself and to the community.
2. A young woman leaves to a more or less manipulated fate the task of deciding for her if she must go on living.
3. A man submits himself to trial by fire or water to show his innocence.
4. A believer confronts a mortal danger to confound the unbeliever. (02:183)

"Baudelaire once wrote: 'Life has but one true charm, the charm of the Game. What do we care whether we win or lose?'" (02:188) from *Fusees*

APPENDIX B

CLASSIFYING SUICIDAL ACTIVITY

Charles Neuringer in his article "Problems of Assessing Suicidal Risk" has provided a useful list for classifying suicidal activity:

Intentional: "an act consciously initiated by an individual, with full awareness of the consequences of the undertaking." Under this category, there are three special cases: "(1) 'Altruistic Suicide'... which refers to individuals who give up their lives so that a cause might prosper. (2) 'Existential Suicide':...that man comes to the 'insight' that life is an absurdity and therefore hollow and empty... (3) 'Surcease Suicide': a category exclusively set aside for individuals who, because of intractable pain, decide that they had better kill themselves. (09:7-8)

Psychotic: "seem to be motivated by psychotic ideation, the intention being not to die. A paranoid schizophrenic patient may die because of an attempt to cut out 'bad' parts of himself that reside deep within his body." (09:8)

Automatization: the individual "act[s] in a nonconscious, automatic manner...illustrated by the individual who is extremely tense and ingests a sedative in order to calm himself. The desired effect may not be forthcoming, and a second barbituate is ingested...he may take more and more barbituates until he collapses and dies. (09:8)

Chronic: "refers to long term self-mutilation and self-defeating mechanisms. Alcoholism, drug addiction, polysurgery, and accident proneness can be given as examples. The intention is to die slowly, inch by inch." (09:8)

Manipulation: "the individual makes an attempt that does not have an element of lethality. It is in essence a warning, a manipulation, and a plea." (09:8)

Accidental: "a person may die accidentally because a suicidal attempt has 'backfired.' A woman who ingests barbituates may have the primary aim of manipulation, but her ignorance as to the effects of barbituates may prove to be fatal. (09:9)

Neglect: "Death may come about through the sheer negligence of an individual." (09:9)

Self-destructive: "People can be said to be suicidal if they overeat, smoke too many cigarettes, climb mountains, pass on the right when driving on a highway, hunt mountain lions, cross the street against the signal lights, etc. In some ways they are taking unnecessary chances with their lives." (09:9)

Suicidal Threats: "A person is said to be suicidal if he threatens to kill himself." (09:9)

Suicidal Thinking: "A person is considered to be suicidal if he thinks about killing himself." (09:9)

Test Suicide: "a man is considered to be suicidal if he gives suicidal and/or depressive responses on psychological tests, especially projective personality tests." (09:9)

APPENDIX C

EVALUATING A SUICIDE

Here is a list of symptoms of potential suicide that may help you make a positive evaluation. They are in no special order and are not of equal weight, but the more of these symptoms the individual exhibits the more likely it is that he is suicidal:

1. Means. Has he a suitable suicidal tool available? This factor carries double weight if the person frequently mentions that he has the means.
2. Previous Attempt. Recent studies corroborate that approximately 75 percent of accomplished suicides have made a previous attempt.
3. Family History. Statistically persons who have had a suicide in the family (especially one or both parents) are more likely to commit or attempt suicide than those who have not.
4. Lack of Roots. Very few persons commit suicide in the town or region of their birth. The farther away from home, family connections, and close friends a person gets, the more likely suicide becomes.
5. Withdrawal. The potential suicide often systematically eliminates social contacts. He drops out of his club, his church, his job, and avoids old friends. Then he can reasonably say, "I'm not needed."
6. Confusion. The potential suicide has a marked inability to separate and evaluate problems. He may say in the same breath, "My wife has left me and I'm two payments past due on the TV set." He cannot deal effectively with many of his problems because he cannot clear his mind of others.
7. A Vague Illness. He will often complain about indefinite physical illness, "an ache all over feeling," or chemical psychosomatic signs are important because they reflect a high degree of disorganization.
8. Urge to Kill. The potential suicide may be seeking revenge, thinking, "You may be sorry when I'm gone." This is a dangerous attitude because it may give birth to homicide.

9. Fear of the Future. Although it sounds incongruous, many persons commit suicide because they fear death. "I know it's cowardly to think of suicide," they say, but actually they are thinking that if they can accomplish suicide they won't have to fear the things that really worry them.

10. Financial Reverse. Here it is apparently the loss of status as much as the loss of money that is significant.

11. Rationalization. Occasionally the potential suicide will attempt an aggressive defense of suicide. This is especially true in the cases where the subject is following the footsteps of a relative.

12. Negative Protest. This is a tricky factor. If a person tells you in an overemphatic manner, that he is not contemplating suicide, be careful.

13. A Feeling of Failure. Despite any past successes, the potential suicide will harp on his failures, even small ones. He will say he is inefficient, forgetful, and makes mistakes that others notice. (50:n.p.)

APPENDIX D

ASSESSMENT OF SUICIDAL RISK

BEHAVIOR OR SYMPTOM	INTENSITY OF RISK		
	LOW	MODERATE	HIGH
Anxiety	Mild	Moderate	High, or panic state
Depression	Mild	Moderate	Severe
Isolation/ withdrawal	Vague feelings of depression, no withdrawal	Some feelings of helplessness, hopelessness, and withdrawal	Hopeless, helpless, withdrawn, and self-deprecating
Daily functioning	Fairly good in most activities	Moderately good in some activities	Not good in any activities
Resources	Several	Some	Few or none
Coping strategies	Generally constructive	Some that are constructive	Predominantly destructive
Significant others	Several who are available	Few or only one available	Only one, or none available
Psychiatric help in past	None, or positive attitude toward	Yes, and moderately satisfied with	Negative view of help received
Life style	Stable	Moderately stable or unstable	Unstable
Alcohol/drug use	Infrequently to excess	Frequently to excess	Continual abuse
Previous suicide attempts	None, or of low lethality	None to one or more of moderate lethality	None to multiple attempts of high lethality
Disorientation/ disorganization	None	Some	Marked
Hostility	Little or none	Some	Marked
Suicidal plan	Vague, fleeting thoughts but no plan	Frequent thoughts, occasional ideas about a plan	Frequent or constant thought with a specific plan

(50:56)

APPENDIX E

SUICIDE ASSESSMENT

Douglas J. Freeman, et al., have developed the "Reversibility of Method" and "Probability of Intervention" Scales that can be used in matrix form for assessing the individual's intentionality towards a successful suicide. (09:23-25)

RATING OF REVERSIBILITY OF METHOD

Rating

- 1 **Complete Reversibility of Method:**
Ingestion of aspirin or other commercial drug items (such as Excedrin®, Bufferin®, and Midol®; antihistamines, or other non-toxic household substances (such as baking powder or mouthwashes).
- 2 **Probable and Expected Reversibility of Method:**
Ingestion of 10 or more tranquilizers or nonprescription sleeping pills (such as Sominex®, or pep pills). Ingestion of 10 or more stimulants (such as Serpasil®, reserpine, Raudixin®, Thorazine®, Compazine®, Dartal®, Mellaril®, Permitil®, Trilafon®, Stelazine®, meprobamate; Librium®, valium, Miltown®, and Equanil®).
- 3 **Questionable Reversibility of Method:**
Ingestion of 10 or more soporific medications, poisons, large amounts or combinations of several drugs, or narcotics (barbiturates: phenobarbital, sodium butisol, Nembutal®, Seconal®, Sodium amytal®, tuinal; non-barbiturate hypnotics: bromides, chloral hydrate, paraldehyde, bromural, Carbrital Kapseal®, halabar; narcotics: morphine, Demerol®, Darvon®).
- 4 **Improbable and Unexpected Reversibility of Method:**
Attempted drowning, carbon monoxide suffocation, domestic gas suffocation, suffocation.
Deep cuts to the throat.
Jumping from a low place (less than 20 feet).
- 5 **Remote or No Chance for Reversibility of Method:**
Gunshot in vital area (such as trunk of body or head).
Jumping from a high place (more than 20 feet).
Hanging (feet above ground).

RATING OF PROBABILITY OF INTERVENTION

Rating

- 1 **Certain Intervention:**
 Act committed in the presence of another person.
- 2 **Probable Intervention:**
 An act committed with another person in the immediate vicinity but not visibly present (such as in the same household).
- 3 **Ambiguous Chance of Intervention:**
 Act committed by person alone, with no certainty of immediate assistance; however, a reasonable chance for intervention exists (such as the victim is aware of the impending arrival of others).
- 4 **Improbable Intervention:**
 Act committed by person alone, with intervention by a passerby possible although not expected (such as a motel room, an office late at night, or home alone with no one expected).
- 5 **Chances of Intervention Remote:**
 Act committed by person alone in a solitary or isolated place without access to telephone (such as a wooded area, cemetery, etc.).

Both scales are 5-point ordinal scales designed to accommodate and represent the circumstances surrounding an individual's suicide attempt. (09:23-25)

APPENDIX F

SIX STEPS ON THE MANAGEMENT OF A SUICIDAL PERSON

1. Establishing a relationship, maintaining contact, and obtaining information.
The helper must attempt to establish a relationship with the suicidal person, if none is pre-existent. The association should be one of mutual trust and respect and be characterized by a free flow of feelings and information. It is important that contact with the suicidal person be maintained as long as is necessary.
2. Identification and clarification of the focal problems.
The focal problem should be identified and clarified. Frequently the suicidal person is confused and disorganized. He is experiencing chaotic feelings, and may have great difficulty in defining precisely what the problem is. Frequently once the problem has been identified, the [individual] experiences a feeling of relief and is able to place his life in better perspective.
3. Evaluation of the suicidal potential.
The helper will try to evaluate the suicidal danger which the [individual] represents, so that the response will be appropriate.
4. Assessment of strengths and resources.
In addition to defining the nature and seriousness of the problem, the helper will attempt to assess the person's strengths and resources. The suicidal person often feels as though he has no assets upon which he can draw. Careful examination of his situation usually reveals resources which he had not thought of and which can make an important difference to him.
5. Mobilization of [individual's] and others' resources.
All the [individual's] resources, those within his own personality and those external to himself, should be mobilized. The helper should encourage the [individual] to do everything that he can for himself and be willing to help with what the [individual] cannot manage.
6. Formulation of a Therapy Plan and the initiation of appropriate action.
Some therapeutic plan must be developed and implemented. It may include hospitalization, psychotherapy, family counseling, or whatever else seems appropriate and helpful. Whatever the plan, a suicidal crisis calls for action of some sort, and the helper accepts the responsibility to aid in its conception and implementation. (50:n.p.)

REFERENCES

BOOKS

01. Alvarez, A. The Savage God: A Study of Suicide. New York: Random House, 1972.
02. Baechler, Jean. Suicides. Translated by Barry Cooper. Foreword by Raymond Aron. New York: Basic Books, Inc., 1979.
03. deCatanzaro, Denys. Suicide and Self-Damaging Behavior: A Sociobiological Perspective. New York: Academic Press, 1981.
04. Durkheim, E. Suicide: A Study in Sociology. Translated by John A. Spaulding and George Simpson. Glencoe: The Free Press, 1951.
05. Encyclopedia Britannica. 14th ed., S.v. "Suicide."
06. Husain, Syed Arshad and Vandiver, Trish. Suicide in Children and Adolescence. New York: SP Medical and Scientific Books, 1984.
07. McIntosh, John L. Research on Suicide: A Bibliography. Bibliographies and Indexes in Psychology, Number 2. Westport, Connecticut: Greenwood Press, 1985.
08. Motto, Jerome A.; Brooks, Richard W.; Ross, Charlotte P.; and Allen, Nancy H. Standards for Suicide Prevention & Crisis Centers. New York: Behavioral Publications, 1974.
09. Neuringer, Charles, ed. Psychological Assessment of Suicidal Risk. Springfield, IL: Charles C. Thomas, 1974.
10. Roberts, Albert R., comp. and ed. Self-Destructive Behavior. Springfield, IL: Charles C. Thomas, 1975.
11. Shneidman, Edwin B.; Farberow, Norman L.; and Litman, Robert E. The Psychology of Suicide. New York: Science House, 1970.
12. Silverman, Charlotte. The Epidemiology of Depression. Baltimore: John Hopkins Press, 1968.
13. U. S. Army. The Chief of Research, Development and Acquisition. Proceedings of the Twenty-Ninth Conference on the Design of Experiments in Army Research Development and Testing. ARO Report 84-2, n.d.

14. U. S. Congress. Senate Subcommittee on Juvenile Justice. Teenage Suicide. 98th Cong., 2nd Sess., October 3, 1984.
15. World Health Organization. Prevention of Suicide. Geneva: World Health Organization, 1968.

PERIODICALS

16. Alessi, Norman E., et al. "Suicidal Behavior Among Serious Juvenile Offenders." In American Journal of Psychiatry. Vol. 141, No 2 (February 1984):286-7.
17. Beck, Aaron T.; Steer, Robert A.; Kovacs, Maria; and Garrison, Betsy. "Hopelessness and Eventual Suicide: A 10-Year Prospective Study of Patients Hospitalized With Suicidal Ideation." In American Journal of Psychiatry.
18. Berman, Alan L. and Carroll, Teresa A. "Adolescent Suicide: A Critical Review." In Death Education. Vol. 8 Supplement, (1984):53-64.
19. Chyatte, Conrad.; and Smith, Vann. "Brain Asymmetry Predicts Suicide Among Navy Alcohol Abusers." In Military Medicine. Vol. 146, No. 6 (June 1981):277-278.
20. Cole, William. "Early Warning Signals of Teenage Suicide." In Better Homes and Gardens. (October 1985):22.
21. Datel, William E. "The Reliability of Mortality Count and Suicide Count in the United States Army." In Military Medicine. Vol. 144, No. 8 (August 1979):509-512.
22. Datel, William E. and Johnson, Arnold W. "Suicide in United States Army Personnel, 1975-1976." In Military Medicine. Vol. 144, No. 4 (April 1979):239-244.
23. Datel, William E. and Jones, Franklin D. "Suicide in United States Army Personnel, 1979-1980." In Military Medicine. Vol. 147, No 10 (October 1982):843-847.
24. Datel, William E; Jones, Franklin D.; and Esposito, Maria E. "Suicide in United States Army Personnel, 1977-1978." In Military Medicine. Vol. 146, No. 6 (June 1981):387-392.
25. Domino, George, et al. "Attitudes Towards Suicide: A Factor Analytic Approach." In Journal of Clinical Psychology. Vol. 38, No. 2 (April 1983):257-262.

26. Draper, Edgar. "A Developmental Theory of Suicide." In Comprehensive Psychiatry. Vol. 17, No. 1 (January/February 1976):63-80.
27. Hipple, John. "Youth Suicide: The Preventable Tragedy." In Military Family. Vol. 4, No. (July/August 1984):3-4.
28. Horan, Dennis J. and Grant, Edward R. "Suicide: The Next Pro-Life Frontier." In Studies in Law and Medicine. (Fall 1982):31-37.
29. Inman, David J., et al. "The Relationship Between Suicide Knowledge and Suicide Interviewing Skill." In Death Education. Vol. 8, Nos. 2-3 (1984):179-84.
30. McKenry, Patrick C. and Kelley, Coleen. "The Role of Drugs in Adolescent Suicide Attempts." In Suicide and Life-Threatening Behavior, Vol. 13, No. 3 (Fall 1983):166-175.
31. Neimeyer, Robert A. "Toward a Personal Construct Conceptualization of Depression and Suicide." In Death Education, Vol. 7, Nos. 2-3 (Summer-Fall 1983): 127-173.
32. Peck, Michael. "Youth Suicide." In Death Education, Vol. 6, (1982):29-47.
33. Ray, Lynda Y. and Johnson, Norbert. "Adolescent Suicide." In The Personnel and Guidance Journal. Vol. 62, No. 3 (November 1983):131-4.
34. Robbins, Douglas R.; and Alessi, Norman E. "Depressive Symptoms and Suicidal Behavior in Adolescents." In American Journal of Psychiatry. Vol. 142, No. 5 (May 1985):588-592.
35. Roose, Steven P., et al. "Depression, Delusions, and Suicide." In American Journal of Psychiatry. Vol. 140, No 9 (September 1983):1159-1162.
36. Ross, Charlotte P. "Mobilizing Schools for Suicide Prevention." In Suicide and Life-Threatening Behavior. Vol. 10, No. 4 (Winter 1980):239-244.
37. Tishler, Carl L.; McKenry, Patrick C.; Morgan, Karen Christman. "Adolescent Suicide Attempts: Some Significant Factors." In Suicide and Life-Threatening Behavior. Vol. 11, No. 2 (Summer 1981):86-92.
38. Wasileski, Mary. "Characteristics of Suicide Attempters in a Marine Corps Population." In Military Medicine, Vol. 147, No 10 (October 1982):818-823.
39. Watson, Charles G, et al. "Suicide and the MMPI: A Cross Validation of Predictors." In Journal of Clinical Psychology. Vol. 40, No. 1 (January 1984):115-118.

PAMPHLETS

40. The American Association of Suicidology and Merck Sharp & Dohme. "Suicide and How to Prevent It." West Point, PA: Merck Sharp & Dohme, 1977.
41. Ibid. "Before It's Too Late: What to do when someone you know attempts suicide." West Point, PA: Merck Sharp & Dohme, n.d.
42. Ibid. "Suicide in Young People." West Point, PA: Merck Sharp & Dohme, n.d.
43. Ibid. "Suicide in Youth and What You Can Do About It: A Guide for School Personnel." West Point, PA: Merck Sharp & Dohme, n.d.
44. Ibid. "Suicide in Youth and What You Can Do About It: A Guide for Students." West Point, PA: Merck Sharp & Dohme, n.d.
45. Ibid. "Suicide--it doesn't have to happen." West Point, PA: Merck Sharp & Dohme, n.d.
46. Ibid. "Suicide Prevention In the Classroom: A Teacher's Guide to Curriculum." West Point, PA: Merck Sharp & Dohme, n.d.
47. Community Mental Health Service, Department of Psychiatry. "A Commander's Guide to Suicide Prevention and Management." Fort Sam Houston, TX. 24 April 1984.
48. 55th Medical Detachment and USA MEDDAC. "Fort Knox Leaders' Guide to Suicide Prevention." Fort Knox. N.d.

MISCELLANEOUS MATERIALS

49. Berman, Alan. "Adolescent Suicide: Issues and Challenges." From an unpublished manuscript. Washington Psychological Center, P.C.; 2139 Wisconsin Avenue, Washington, DC 20007. N.d.
50. Los Angeles Suicide Prevention Center. "Suicide - Assessment & Intervention." Los Angeles, CA. N.d.
51. National Center for Health Statistics. "Final 1982 Suicide Statistics." As reported in the Monthly Vital Statistics Report of the National Center for Health Statistics, December 20, 1984.
52. National Library of Medicine. "No. 79-6: Suicide or Depression in Childhood and Adolescence." Washington, DC: Department of Health, Education and Welfare, 1979.

53. The Samaritans. "Factors to Consider When Evaluating Suicide Risk." Paper. 500 Commonwealth Avenue, Kenmore Square, Boston, MA. N.d.
54. Ibid. "Signs of Depression and Suicide Risk." Paper. N.d.
55. Ibid. "Suicide: What You Can Do to Help." Paper. N.d.
56. Turner, Jerome R. "Suicide." From an unpublished manuscript.
57. United States Army. Directorate of Human Resources Development, Office of the Deputy Chief of Staff for Personnel. "United States Army Guide to the Prevention of Suicide and Self-Destructive Behavior."
58. United States Army. Army Chaplains Board. "Caring: A Positive Approach to Suicide Prevention." Unpublished manuscript. Fort Monmouth, NJ. N.d.
59. United States Navy. Naval Health Research Center. "Completed Suicide in the Navy and Marine Corps." by R. B. Chaffee. Report No. 82-17. San Diego, CA: Naval Health Research Center. December 1982.
60. Ibid. "Navy and Marine Corps Completed Suicides by Year and Branch of Services: 1974-1984." From an unpublished manuscript.
61. Ibid. "Request for information on completed suicide among Navy personnel." 39/30RBC/frj, Ser 4595, 18 April 1983.
62. Ibid. "Temporal Variation in Completed Suicide." by R. B. Chaffee and P. Coben. Report No. 83-9. San Diego, CA: Naval Health Research Center. February 1983.